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Common Programs Observed in Survivors of Satanic Ritualistic Abuse

Common Programs Observed in Survivors of Satanic Ritualistic Abuse

describes crimes of abuse and programming techniques

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Introduction

Increasingly, cases of Multiple Personality Disorder (MPD) and Satanic Ritualistic Abuse (SRA) are being reported in the psychotherapeutic community. Though controversy concerning authenticity remains, such cases are slowly gaining in acceptability as a genuine social and psychopathological phenomenon. Concurrently, the etiological underpinnings and treatment demands of these special patients are being unraveled and understood as never before. As a result, it is becoming increasingly clear that perhaps the most demanding treatment aspects of such cases concern the problems posed by what is known as “cult programming.”

So called cult “programs” are really no more than conditioned stimulus-response sequences consistent with basic learning theory. Such conditioning is achieved through a large variety of sophisticated and sadistic mind control strategies involving the combined application of physical pain, double-bind coercion, psychological terror, and split brain stimulation. All programs are stimulus-sensate triggered. Thus, programs may be enacted (triggered) via auditory, visual, tactile, olfactory and/or gustatory modalities. Classical, operant, and observational/modeling paradigms all are utilized by the cults and their “programmers.” Finally, it is important to note that virtually all cult programs will possess a variety of secondary and tertiary back-ups — perhaps several layers of each.

The following is a preliminary and evolving listing of the different types of cult programming observed in my own brave patients, as well as in those of my colleagues and consultees. All such patients are survivors of Satanic Ritualistic Abuse with a diagnosis of Multiple Personality Disorder.

The purpose of this compilation is to educate the therapist treating MPD and SRA about commonly observed programs in similar survivors. It is hoped that the following will aid in the identification of cult mind control programming in therapists’ patients, as well as to generically disseminate important information hitherto known to but a relatively few SRA specialists. The more we know about cult techniques and methodologies, the easier it becomes to effectively treat these courageous patients.

Self-Injury Programming

1). Cutting Programs

As children, patients have been “taught” by the cult when and how to cut. These programs tend to be triggered as a means of punishment, as well as to reinforce earlier “compliance” or “shutdown” injunctions (e.g., “Don’t betray the coven.”)

I recommend that the therapist pay specific attention to the pattern, location and implement of the cutting — each may serve as a signature of the original program, involved alter (alternate personality), and/or cult programmer. I further recommend photographing and or diagramming the wounds from each of the cutting episodes for later comparisons.

The cutting implements themselves may be special “gifts” of the programmer (used during the original programming session), which the patient may keep secretly hidden for years and use only when the urge to cut is specifically triggered. Finally, many cutting programs have been conditioned in such a way as to “progress” to suicide programs as “needed.”

2). Burning Programs

As is the case with cutting programs, the location and modality of the burn injuries are significant. The therapist may also wish to map the burn wounds. Common modes of burning include: cigarettes, lighters, hot metal implements (i.e., knives, rods, wands), and/or a variety of scalding (or flammable) liquids and caustic chemicals.

3). Miscellaneous Self-Injury Programs

Types of specific self-injury programs are as numerous as there are ways to injure oneself. Besides being conditioned to cut and burn, we have also routinely seen programs designed to create within the survivor: (1) “accident” proneness, (2) failure to eat, (3) ingestion of injurious materials and poisons, (4) failure to sleep, (5) failure to take needed medication, and (6) the intentional breaking of one’s own bones — particularly hands, fingers, arms and legs.

Lethal Programming

1). Suicide Programs

SRA survivors are routinely conditioned to attempt to kill themselves when they and/or the therapist, are deemed to be getting too close to material damaging to the cult, or when the cult feels it has lost all other forms of control over the patient.

Expect these to be present in virtually all SRA survivors. Recent clinical experience has raised serious questions concerning the once widely held “one true suicide program” concept. Indeed, while many patients do have but one or two such programs, many more often exist. Additionally, there may be more than one suicide program per alter, and more than one trigger per program.

Identified suicide methodologies have included: shooting, hanging, cutting, stabbing, poisoning, overdosing, auto “accidents,” leaping from buildings, starvation, etc.

It has been my experience that the original cult suicide programming sessions will often NOT involve the use of dissociation enhancing medication, apparently so as to keep the memory as clear and distinct as possible.

2). Assassination Programs

When someone in the survivor’s environment is deemed by the cult to have become too much of a liability, the patient may in some cases by triggered to attempt to kill that person. Most likely such programming will be set in against a supportive significant-other (e.g., husband, boyfriend), or against the therapist.

As is the case in self-injury programs, the special means/implements (e.g., guns, knives, poison, etc.) of the assassination program are often “given” to the patient by the cult.

The primary intent of the cult may not be the actual death of the assassination target, so much as the discrediting of the patient as a “murderer” or “attempted murderer.”

Cult Control Programming

1). Reporting Programs

Patients are conditioned to routinely contact and report back to the cult. These programs may be time-triggered (every month, full moon, etc.), date-triggered (i.e., corresponding to cult “holidays”, etc.), or situationally triggered (i.e., host personality enters therapy, reveals cult “secrets,” etc.). Such programs keep the cult updated on the patient’s daily life, as well as with the ongoing work in therapy. Further, specific intelligence information may be gathered about the therapist and treatment facility, and reported back to the cult.

Particularly prevalent with such conditioning are several layers of back-up reporting programs. Of course, along with back-up programs will come a large contingent of back-up reporting alters. Never assume you’ve found all the reporting alters in the patient’s system. Always assume that reporting exists.

2). Access Programs

This refers to cult access into the survivors' personality system. These programs allow the cults to access the patient's personality system through specific (usually cult-created) alters. This access is achieved through a large variety of triggers, including whistles, electronic tones, spoken phrases, touch, etc. Once accessed, a myriad of other programs may be triggered and/or reinforced by the cult.

3). Return Programs (Call Backs)

Such programs are designed to manipulate patients to return to the cult for rituals and/or further programming or to "escape" from therapy. The patient may be conditioned to respond to phone cues, to follow a specific contact cult member upon sight, and/or to meet a cult "contact" at a predetermined location (i.e., "safe house").

4). Reminder-Reinforcement Programs

May be used as a "reminder" of the patient's "vows" to the larger cult or subordinate coven. These are programs often enacted via phone or touch triggers (e.g., three series of three taps on shoulder or knee, a rapid series of six electronic tones, spoken phrases, etc.). Program triggers frequently include "gifts" from the cult given during childhood (e.g., stuffed animals, music boxes, etc.). Visually, certain colors may also serve the same purpose. Cult-related colors (particularly red, purple and black) are commonly presented to the survivor in the form(s) of a cult-contact's apparel, a letter or envelope, etc. These programs appear to be primarily designed to re-install fear and cult compliance.

Not uncommonly, a survivor may be triggered to compulsively engage in degrading or self-injurious activities so as to reinforce a variety of other "in place" cult conditioned responses.

Therapy Interference Programming

1). Scrambling Programs

These are programs intended to confuse, disorganize and/or block the patient's alter system, emerging memories, thought processes, and/or incoming information. Often, there are specific alters designated by the cult programmer to perform this function (e.g., "The Scrambler"). Reduced ability to "switch," speak, write, draw, read, and/or remember previous sessions/work are potential tip-offs to the enactment of a scrambling program.

Such programs may specifically target the therapist. For example, the incoming words and/or visual images of the therapist may be scrambled or garbled. The effect will often be that the survivor experiences the therapist as looking and/or sounding threatening, abandoning, or incompetent.

2). Flooding Programs

Such programs are enacted by the cult in order to interfere with therapeutic progress/process by overwhelming the patient. This is achieved by triggering the patient to have a flood of painful and frightening cognitive and/or somatic memories enter consciousness simultaneously, thereby significantly increasing post-traumatic stress disorder (PTSD) symptomatology and suppressing the functionality of the patient. A wide variety of triggers may be utilized.

3). Recycle Programs — (Ray & Reagor, 1991)

These are programs which act to quickly re-dissociate memories which the therapist has worked to abreact and re-associate. The therapist may return the next day to find he/she must redo the work from the previous therapy session. Such programs must be neutralized before the re-dissociated material may be effectively re-associated.

4). Cover Programs — (Ray & Reagor, 1991)

Similar to “screen memories;” these are programmed memories laid in by the cult to distract from, or distort, the true ritual abuse memory. A secondary purpose of these programs is to discredit the survivor’s memories with “unbelievable” content. For example, a ritual involving pain and “medical” paraphernalia might be “covered” with a memory of UFO abduction and experimentation.

5). Verbal Response Programs

These are programs designed to provide “acceptable” answers to cult-related, system-related or alter-related inquiries which may be posed by the therapist or other non-cult supportive persons. Such responses will have been extensively (and painfully) “rehearsed” by the patient and cult programmer.

6). Silence-Shutdown Programs

When enacted, such programs will cause the patient to “stop talking” — to cease revealing information to the therapist or non-cult supportive other. Though such programs may be triggered through a wide variety of modalities, enactment via self-touch triggers are particularly common. Some shutdown programs will be directed toward specific alters, while others are meant for the system in general.

7). Nightmare-Night Terror Programs

Similar to flooding programs, patients are conditioned to become overwhelmed with terrifying images/memories while asleep. Such programs are deeply ingrained and appear to be primarily used for punishment. They serve to keep the patient run-down and fatigued. Often, nightmare programs are triggered or tripped automatically when processing “forbidden” material in therapy.

8). Isolation Programs

Isolation programs may have intra-system or extra-system applications. Within the system, alters may be walled-off (via amnestic barriers) from cooperative alters by cult-loyal alters. Beyond the system, patients may be conditioned to withdraw socially, isolating themselves from helpful resources, etc.

9). Pain Programs

As the name implies, patients may be conditioned to reexperience the physical pain portion of their abuse memories. Generally used as punishment, pain programs may also be enacted to “motivate” the survivor to carry out other programmed injunctions. Such conditioning may be specifically/intentionally triggered by cult, or automatically tripped when processing “forbidden” material in therapy. Electroshock pain appears to be a favorite of the cult-programmers for this particular conditioning paradigm.

10). Rapid Switching Programs

Once enacted, a patient may not be able to finish a sentence without switching three to four times between alters. The problems this creates for the patient's optimal functionality are obvious. This type of conditioning appears to have been programmed via the rapid presentation of preconditioned alter-triggers during the original programming session. The entire original programming experience is then paired with a neutral trigger.

11). Miscellaneous Therapy Interference Programs

Other types of programs observed in SRA survivors designed to interfere with the therapeutic process include those which condition the patient to: (1) not see, (2) not think for self, (3) stay distracted, and (4) become resistant, mistrustful, and/or obnoxious toward the therapist.

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